August 8, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1463-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy with a specialty and board certification in Neurological Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient suffered a work-related injury in ___. He has seen numerous physicians over this period of time, including chiropractic, pain management and orthopedic surgery. He has had the findings of back pain and right leg pain. MRI and CT myelogram confirm a large disc herniation at L4/5, slightly to the right and degenerative in nature. He has had epidural steroid injections and has had medications and physical therapy, none with significant relief.

A nucleoplasty was performed at the L4/5 level, an apparent discogram was not performed, it was requested but not authorized and therefore a discogram was never performed on this individual.

He is not requesting fusion at this level for failure of conservative treatment.

REQUESTED SERVICE

A 360˚ fusion at L4/5 is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

With regards to this patient, the reviewer finds that the fusion should be approved. This patient has met the criteria that is acceptable in the literature. The only thing that is missing is the discogram, and that is unfortunate, but the reviewer does not see how it can be done now after a nucleoplasty, as certainly the results would be confusing.

This patient predominantly has back pain with some leg pain for which interbody fusion is certainly acceptable. There is significant literature on interbody fusions, that it has a 50% improvement rate. Nucleoplasty has been tried and did not work. According to numerous studies on interbody fusion, this patient does meet that criteria and this procedure should be approved.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

References:

1. Radiographic Assessment of Interbody Fusion Using Recombinant Human Bone Morphogenetic Protein Type 2, Spine 28(4):372-377. ___; ___. ___, CCRC
2. Outcome of Posterior Lumbar Interbody Fusion Versus Posterolataeral Fusion for Spondylolytic Spondylolisthesis, Spine 27(14):1536-1542. ___, ___.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 8th day of August 2003.